



King's Research Portal

DOI:

[10.1080/17441692.2019.1587639](https://doi.org/10.1080/17441692.2019.1587639)

Document Version

Peer reviewed version

[Link to publication record in King's Research Portal](#)

Citation for published version (APA):

Adams, V., Behague, D. P., Caduff, C. A., Löwy, I., & Ortega, F. (2019). Re-Imagining Global Health Through Social Medicine. *Global Public Health*, 14(10), 1383-1400. <https://doi.org/10.1080/17441692.2019.1587639>

Citing this paper

Please note that where the full-text provided on King's Research Portal is the Author Accepted Manuscript or Post-Print version this may differ from the final Published version. If citing, it is advised that you check and use the publisher's definitive version for pagination, volume/issue, and date of publication details. And where the final published version is provided on the Research Portal, if citing you are again advised to check the publisher's website for any subsequent corrections.

General rights

Copyright and moral rights for the publications made accessible in the Research Portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognize and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the Research Portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the Research Portal

Take down policy

If you believe that this document breaches copyright please contact librarypure@kcl.ac.uk providing details, and we will remove access to the work immediately and investigate your claim.

Re-Imagining Global Health Through Social Medicine

Introduction

Social medicine, variously and broadly known as a field that focuses on the social basis of health and illness, has a long history. Before it became formalized as scholarly field and medical discipline in the mid 20th century, social medicine was a topic of interest to social reformers, scholars and health professionals. In this paper, we argue for a re-imagining of global health in and through the conceptual work of social medicine -- a task that draws our attention to the limitations of the field of global health as it is often conceptualized and practiced today.¹

Tracing the history of social medicine, one might say that it has developed differently in response to distinct challenges over the past several centuries. One might even talk about the history of social medicine in the UK, Europe, and later in the US, as having roughly three phases:

- The radical-for-the-time mid-19th Century effort to recognize the social, political and economic conditions of health and illness, demonstrated in the work of Rudolf Virchow (1849);
- The late 19th Century birth of public health institutions for social welfare in which the idea of the population emerged as a primary concern of governance, described carefully by Michel Foucault (2000, 2004, 2012) among others;
- The 20th Century rise of social science critique concerning the social, cultural and political basis for medico-scientific knowledge and the uneven distribution of both health and illness, giving rise to a variety of social medicine commitments across scholarly expertise (from STS to Health Economics, in the work of Archie Cochrane, Thomas McKeown, Agnus Deaton, Michael Marmot to mention a few) and to policy practices across a variety of interventionist sites (from

community clinics to national health programs in a wide variety of countries) (Wilkinson and Pickett, 2009; Porter 2006; Jones et.al. 2014; Gofin 2006).²

Formal research and education programs in social medicine today are positioned as an antidote to biomedicine's entrenched and often reductionist pull toward the pharmacological, molecular and genetic bases of disease and intervention, and social medicine scholars work (often alongside clinicians) to draw attention to therapeutic/preventive interventions that foreground the social conditions of life. New training programs in both social medicine³ and in the more recent 'structural competency' (see Metzl and Hanson 2014) agenda and accompanying publications (Stonington et.al 2018) are just some examples of this, building on many decades of scholarship that show the direct and indirect ties between social inequality and ill-health. Social medicine has been and continues to be promoted as a vast collection of institutional, intellectual and political efforts that are in some ways more prevalent and urgent than ever before.

At the same time, social medicine scholars seem always to remain in an uphill battle for recognition and influence (Waitzkin 1991), as efforts to incorporate information about or concern with the social dimensions of health and healthcare continue to be seen as of limited and lesser importance against competing disciplinary perspectives. One can find scholars and activists relying on what are clearly identifiable social medicine genealogies across a wide array of social scientific and humanities disciplines (from history to global surgery) and yet they do not claim to be doing social medicine. Indeed, rather than being seen as foundational to emerging fields that offer approaches to the "social," social epidemiology, social psychology, population health, health economics, etc. (Bell 2018), these fields often ignore the fact that they are actually doing social medicine at all.⁴ Rarely is social medicine recognized as both primary and foundational to understanding and intervening in health. In this article,

we focus on a particular set of ways that social medicine has been overlooked in one field in particular: the field of global health.

Working in this space, Holmes, Greene and Stonington (2014) have identified four qualities that social medicine could bring to global health:

“multidisciplinary methodologies, rooted in social theory, critically interpretive stance and proclivity to engage with social aspects of clinical and scientific problems. Crucial to all this work is a commitment to rigorous empirical research in the social world: ethnographic engagement, historical analysis, sociological and social epidemiological analysis and contextual ethics” (2014:3).

Our article picks up where these authors have opened up a critical space for imagining how social medicine might be put in conversation with global health, starting with interrogating what we mean by both ‘global health’ and ‘the social.’

Global health is not a given but rather a new regime of representation and intervention -- a 21st century imperative. As scholars have shown, the shift from international health to global health over the last few decades could be characterised by a number of large-scale changes: the weakening of the WHO; the rise of health interests at the World Bank (and IMF); the emergence of powerful new private actors such as the Bill and Melinda Gates Foundation and the quasi private Global Fund; the internationalization of pharmaceutical research and Contract Research Organization (CRO) markets; the truncated success of International Health Development programs; the shift in the morbidity profiles made visible by such instruments as the DALY, the QALY, and the International Burden of Disease index; and the rise of a "commerce/security/disease" nexus (Brown et. al.2006; King 2002; Birn 2009; Fassin 2012; Erikson 2016; Gaudilliere 2014; Adams 2013a, 2016; Caduff 2015).⁵ While these changes have endowed global health institutions and expert-elites working within them with considerable

traction, so have these scholars noted that these changes have led to a great many distortions and inequities in the way public health is practiced (Béhague et al 2009). This has added a layer of complexity to what has already been a vexed history of international health efforts that have been deeply entangled with colonialist and neo-colonialist ventures. It is also useful to remember that on the ground in many parts of the world, global health – like international health before it – is often either unfamiliar, of minimal influence, or actively resisted (King 2002; Hodges 2012; Anderson 2014; Dilger and Mattes 2018), making the work of global health an ongoing challenge despite the newness of its name and some of its constitutive elements.

As some scholars have shown, the shift from international to global health has tended to marginalize social medicine perspectives, undermining efforts to work through the social that had begun in the decades prior. Aggleton and Parker (2015) describe how biomedical reductionism was promoted by major global health players (including the WHO and Gates Foundation) in relation to HIV prevention and treatment, as pharmaceutical solutions supplanted calls for more community health efforts. Despite push back on this from Michael Marmot and his efforts with the WHO Commission on the Social Determinants of Health (2008),⁶ the even nominal effort to include social medicine perspectives were largely dropped after the global financial crisis and since then the return to biomedical hegemony in both research and policy of the major global health institutions has lingered. One indication of this is the turn to both evidence-based science and the revitalization of magic-bullet and often pharmaceutically-driven thinking as drivers of policy and planning (Cueto 2013). Our notion of the limitations of global health points to these ongoing challenges and prompts our consideration of ways in which social medicine could be useful but, to be more specific, to a consideration of how the notion of the ‘social’ in that social medicine might be thoughtfully interrogated in new ways.

Our argument is that many global health programs work with a very particular and limited

conception of ‘the social’ – one that some endeavors in social medicine may also sometimes unwittingly reproduce such as in the ‘social determinants of health model’ adopted by the WHO’s commission, mentioned above. Our goal is to map some of the ways that the social is being interrogated in social science these days and to set those concepts in conversation with what is going on in global health rather than to provide an exhaustive index of what global health currently offers.⁷ In other words, this paper does not offer a list of current failures in global health so much as a constructive effort to set two fields of scholarship in conversation with one another. To be sure, our aim is not to argue that today’s global health is entirely unconcerned with the social, or that it is the only task of social medicine to put the social more strongly at the centre of global health interventions. Rather, our motivation is in exploring how the particular notion of ‘the social’ currently used in global health needs reconsideration along the lines that are being redrawn in critical circles of social medicine today because failing to do so risks reproducing some important limitations to global health.

By this we mean that categories like gender, class, race, and power are used widely in global health but they are often taken as self-evident entities that exist in the world like trees or stones when, in fact, they are mutable, synergistic, and variable concepts that have a complex role in helping us understand people’s lives. One cannot talk about gender, for instance, independent of the ways in which gender is understood and put into practice in everyday life in a multiplicity of ways across geographic and cultural places. Global health needs to move beyond a naturalized understanding of the social as either cause or context, and to recognize the analytic violence that scholars commit by simply assuming that certain people “belong” to a “family” or “gender” or “race” or “nation”. As Veena Das (2003, 101) underscores “an individual cannot be said to ‘belong’ to her kinship network, community or neighbourhood as, say, water belongs to the bottle or clothes belong to the wardrobe.” Any “belonging” to the social is fraught with tensions, and the struggles that we witness are often struggles around

normative sociality. The mechanical concept of the social that underlines much work in global health – for instance, in courses on the so-called “social and structural determinants of health” and in textbooks on global health that refer to these categories with little exploration of how they diverge in practice – needs to be replaced with a far more flexible, intersectional and contingent reframing of the social. Given the amount of critical social science work that has gone into showing that none of these categories are self-evident, we are surprised at how often reference to social factors appear as mere background information as givens (for instance, as gendered, caste, class, ethnic identities that have no bearing on the analysis). Just as the mechanical application of the concept of ‘cultural determinants of health’ needed to be undone once it was reductionistically used to reproduce essentialist notions of cultural difference in clinical care, so too might we need to undo the damage that reified notions of race, class, gender, nation etc, -- concepts that stand in for ‘the social’ -- do in much global health work today.

In what follows, we consider five terrains in which new conceptualizations of ‘the social’ are unfolding in social theory that may be unfamiliar to some but of great use in global health. These are: 1) reconfigurations of the state and new forms of political activism, 2) philanthrocapitalism and the economization of life, 3) the economy of attention, 4) the challenges of anthropogenic climate change, and 5) the geopolitics of North and South. We explore these terrains in relation to what we see as possible limitations of current global health work, and in so doing question what we identify to be a core biopolitical imaginary that underpins the social-as-site-of-intervention in much of this work. A social medicine approach that advances more complex understanding of the social may even open up the black box of ‘inequity’ that has often been largely taken for granted across the social sciences, helping us to think about what methodologies work best for this reconceptualizing.

Reconfigurations of the state

Social medicine scholars have long relied on the assumption that in order to do social medicine, it helps to have a strong nation-state -- a governing body that can attend to the health of the social body or, at a minimum, that can support the political will for such. Global health has recently called for the same, assuming the state must be involved in provisioning health infrastructure, manpower, political will. A good example of this is the Lancet's Global Health 2035⁸ manifesto calling for state subsidized universal health coverage in low to median income nations, replicating the successes of the '4 C' countries (Chile, China, Costa Rica and Cuba) where nationally subsidized health programs have been strong (Jamison et. al. 2013). This foundational biopolitical imaginary, and the nostalgia for the state as guardian of the social that it implies, needs critical re-evaluation given the fact that much global health work has had, as many have pointed out, a very ambivalent relationship with the nation state.

Thus, while on the one hand many global health programs and agendas assume and promote the notion of a strong state that prioritizes and invests in the health of its population, we also witness, on the other hand, a weakening of the state by de-territorialisations and dis-aggregations arising from intensifying political and economic processes of liberalization and globalization in global health work accompanied by the relative decline in bilateral and multilateral state aid, and the rise in support from NGOs and private philanthropies large and small. These institutional shifts, replicated in the production of the Global Health 2035 report itself (which included no state representatives), have enabled much of the work of global health to be done with less engagement with state agencies, sometimes without any communication with local or regional branches of countries' ministries of health whatsoever. The willingness and capacity of national governments to manage, coordinate or advise the work of diverse for-profit and not-for-profit NGO interventions has been truncated by these shifts in funding and prioritizing, actually leaving many national health programs underfunded and relatively undeveloped

(Buse 2009; Schrecker 2018). Where private sector corporations, such as Contract Research Organizations, work alongside experimental research interventions funded by non-bilateral agencies like the Gates Foundation (for vaccine studies or antimalarial mosquitos for instance), funding is seldom routed through state health programs or primary care operations (Petryna 2009). Instead, research teams set up as independent centers for data generation and health care delivery, frequently in competition with state-funded institutions even while they still rely on such actors for support (Crane 2013; Geissler and Molineux 2017; Biruk 2018). Relying on NGO aid organizations leads to a patchwork of interventions that can produce radical inequalities and incoherent policy development within countries.⁹

Thus, we need to pay closer attention to what all this means not for the *disappearance* of the state but rather for the *reconfigured role of the state* in health, starting with the fact that the state is by no means a homogenous entity that has been or is everywhere the same.¹⁰ Global health's bifurcated demands of the state to both fulfill dreams of national health while remaining mute (or invisible) while surpassing and succeeding where the state -- and by extension where international health -- has failed does not mean that the power of the state has vanished or that it could suddenly be materialized in robust health coverage programs. On the contrary, in many countries, especially in Africa, the state may be weakening but it nevertheless remains present as a deliberate absence in what Geissler (2015) calls the *para-state*. The para-state forms a tandem shadow architecture made up of biopolitical, non-governmental and market institutions that depend on the ongoing fiction of the state but that escape its power. To be sure, no global health program can work today without at least a minimal involvement of the state. As Geissler underscores, the state "remains tangible in the many people enrolled in its workforce, its buildings and circulations, and its habitual procedures and paper trails; it also remains present in people's claims for care, in state providers' determination to define policies and standards, and even in foreign donors' insistence on working through state 'partners'" (Geissler 2015, 4). At the

same time, what that state is, specifically and variably, needs to be considered carefully in relation to the ways that global health programs and funding streams bypass the channels of decision-making and power that lie traditionally in the governing institutions of states. How global health research projects both stand in for the state by provisioning health care while also undermining the state's authority by funneling most healthcare through the engines and infrastructures of data production offers an example of this social terrain of the para-state (Crane 2013; Tichenor 2016). This arrangement requires us to rethink what 'the social' means in relation to the nation-state. As Geissler notes, this is not the biopolitical state of the 20th century, but rather a shadow of its imagined former self that is sutured together by new biopolitical formations that articulate interventions in new ways. In countries that depend more heavily on aid, global health actually renders ambiguous the state as the key guardian of the health of the social body, *questioning* the extent of its capacity to improve health even while *calling upon* it to act.

The key question to ask, thus, is what this deliberate absence both *enables* and *denies*. Rethinking the meaning of 'the social' in relation to the nation state offers a departure from normative understandings of the state based on the repetition of well-worn ideas of what the state should be, how it should "make" the social and what it should do that, in the end, become utopian hopes. There is no point in continuing to reference Virchow's over-cited (but under-analysed) phrase of *Politik as Medizin im Grossen* when the very ideas of the social, the political, and the medical are rapidly changing, as the state itself is being dismantled and rebuilt as a series of public-private partnerships. We are pointing to the need to study the state as it is reconfiguring, exploring how it interweaves with a global health presence, or not, and investigating the practices of the social it upholds and denies. We must ask how the state materializes on the ground and in everyday life as both a deliberate absence and an imagined presence.

A good example of this conceptual work is in recent ‘mutations in citizenship’ (Ong 2006) that have been identified as a consequence of the flows of markets, technologies and populations that call into question basic oppositions between citizens vs stateless, or territorialized citizenship vs deterritorialized human rights. Citizenship in relation to nation states is supplanted by criteria that are taken as universals: human rights and neoliberal values of flexibility, mobility and entrepreneurialism, biological make-up and the capacity for sheer survival in refugee camps. New claims are mobilized as basis for rights, entitlements and protection that erase old notions of the nation state, even while hardening a call for national borders. These ‘mutations in citizenship’ have also resulted in new arenas of (bio)political activism and citizenship formation (Rose and Novas 2005; Vidal and Ortega 2017), shifting boundaries between state and society, private and public, and promoting new objects of contestation, new forums for debate, new issues for democracy and new styles of political activism (Rose 2007; Ortega 2014). They achieve new sensibilities of care and survival in and through therapeutic belonging and rites (Tiktin 2011; Nguyen 2013). The fact that para-states often use of philanthrocapitalism as an engine for fueling such politics, for instance, in view of our critique above, also deserves more close attention (which we offer, below).

The notion advanced by a more careful consideration of ‘the social’ offered by social medicine is one that is attuned to new politics and novel forms of activism that are emerging in domains that may not be identifiable at first glance as health or medical domains (from the Arab Spring to #metoo and #BlackLivesMatter). New social movements and new forms of biosocial activism that organize communities for social justice are able to reveal the worlds of suffering and injustice that have often been made invisible by more simplistic approaches to structural inequality often found in global health and by reference to a traditional notion of the nation-state (Schuller 2016). Notions of sociality are themselves changing as citizenship, biology and community are conjoined in platforms for change. This,

in part, also calls for a new kind of attention to media and social media, but also to the very conceptual work being done in these movements to move the bar forward on social justice.

In sum, while global health programs typically call upon old notions of the nation state and rely on traditional notions of citizenship and social justice to advance health, the social medicine approach we advanced in this paper calls for more attentiveness to all of these new state absences and presences in relation to calls for ‘capacity building’ or ‘political will’ to advance health. Specifically, how states are reconfigured by various actors who participate in global health as para-states, and how social justice efforts must be conceptualized by new notions of citizenship, biopolitics and community, all matter in ways that many global health programs often overlook by assuming a nation state that may or may not exist in the ways it is often imagined.

Philanthrocapitalism and the Economization of Life

Global health programs have had a tendency to turn all health problems into problems of economy, a pattern tied to the increasing presence of health economists in health planning, and the overarching pull of neoliberalism (McGoey 2015; Adams 2016). Here, too, we argue that a social medicine approach helps us consider the ways that the social has been figured in relation to economics historically and in the present in ways that limit what can be done in global health work today.

Michelle Murphy demonstrates how much of the history of international health has entailed an *economization of life* –a process that began long before we had anything called global health, as the rise of an “historically specific regime of valuation hinged to the macrological figure of the national ‘economy.’ ... [by which] value could be generated by optimizing aggregate life chances ... relative to the horizon of the economy” (Murphy 2017, 6). Emergent during the 19th century, the economization of life flourished in the postwar development era, especially in family planning and reproductive health where assigning value to specific gendered forms of life “for the sake of the macroeconomy” (Murphy

2017:148) has been normative. Murphy traces these practices further, to their logical end-points under contemporary neoliberalism as big data and corporations now get looped into the phantasmagoric promise of investment in healthy populations: as *vulnerable girls* become rescripted as *emerging markets* and *the poor* are transformed into *microentrepreneurs* (see also Ferguson 2010; Ong 2006). Social medicine helps us pose questions about the value of life outside a framework dominated by naturalized ideas of the “population” and the “economy.” At stake here is how we want to understand ‘the social’ that gets caught up in these economics.

Philanthrocapitalism offers a good case in point of how what we mean by how ‘the social’ matters as it gets looped into efforts of “demarcating human worth and exploiting life chances,” as Murphy says. Philanthrocapitalism mobilizes private wealth and corporate philanthropy for global health and healthcare by way of the model of the free-market, returning us (some would say) to the health aid reminiscent of the colonial era (Vaughan 1991; Bern 2006). But, philanthrocapitalism models tend to hold ‘the social’ as a constant rather than as a variable that must be deciphered in calculating success or failure. Thus, we hear about the *double bottom lines* of social benefit coming from philanthrocapitalism, in which health benefits are garnered alongside fiscal profits in a win-win scenario, displacing older critiques of profits’ inevitable trade offs for health (Adams 2013b). We know that regimes of for-profit charity tend to favor technological and pharmaceutical interventions over interventions that cannot show a profit, and we also know that without evidence of fiscal benefits, perfectly good health projects often get scrapped (Kelly and McGoey 2018). Thus, what work unexplored notions of ‘social benefit’ do in the double bottom line matters a great deal. What would it mean to unpack the notions of ‘social good’ that circulate in claims of success in these transactions?

Social medicine offers a way to interrogate how defining ‘social benefit’ might entail reliance on specific kinds of evidence while erasing others. For instance, global health community leaders rail

against the lacklustre effort on the part of the WHO to convince governments to impose higher taxes on diabetes and other disease-causing foods and consumables (as if consumption depends only on cost). Our hunch is that few of the researchers involved in setting such agendas have any idea how these foods and goods make sense in the social milieus where they are consumed, or even what concepts of social value circulate in relation to their cost (Horton 2018a, 2018b). Similarly, tracking technological fixes such as vaccines and drug distributions as win-win opportunities requires taking into account not just pharmaceutical profits alongside immunization but also the perceived values and actual practices that are displaced by vaccine and pharmaceutical acceptance (Marglin 1988; Hayden 2006; Sobo 2016; Dumit 2012; Peterson 2014). Here unpacking what is meant by ‘social good’ offers different ways of tracking benefit, generating insights that help us understand how and why global health programs (even those with “social determinants” awareness) often fail to achieve health targets even when they are considered successes. Understanding the mechanics of pharmaceuticalization as a set of social displacements and not simply as a sign of effective care is one line of analysis that could be recalled here (Van der Geest and Whyte 1988; Whyte, Van der Geest and Hardon 2003).

Attempts to decouple health from its micro- and macro-financial potentials means reading the social in non-instrumentalist (and non-financial) ways all the way up the line. Thus, the role that social medicine itself has played in the economisations of life needs to be reconsidered. Refusing to take the social as an attribute that is free-standing and yet pliable in relation to the generation of health statistics (showing, for instance, that something is cost-effective or not) opens up the space for thinking about how else we might measure outcomes, how else we might talk about fiscal good, and how we think about value in relation to health. To date, there is little effort to define how *the social* works in these spaces of financial health accountability, little intellectual rigor about the social in the kinds of work being done in these interventions in global health.

The Economy of Attention

One of the advantages of a social medicine approach is the use of a critical analytical repertoire to understand how some health problems are far from the site of sick or ailing bodies. This too, requires thinking in new ways about what constitutes ‘the social’ in global health. Rather than treating the social as the unopened black box of *context* where projects are done, this approach turns the focus on the social apparatus of attention -- an *economy of attention* that is mobilized in global health. What we mean by this is that certain things get more attention than others as part of the advocacy machinery, while other problems go rather unnoticed if not entirely neglected (Storeng & Béhague 2014; Ollila 2005). This is partly a function of how funding for global health works but also a limitation imposed by its shallow understanding of the social. Global health interventions are constituted in and through social iterations that result in making some things visible and other things invisible.

For instance, violence is often overlooked in global health campaigns in lieu of more immediately solvable problems, even when both cause enormous physical suffering and morbidity/mortality. It does not take much to see how conditions of violence exacerbate problems of infectious diseases, interrupt prevention campaigns, and undermine health gains with a single machete, the shot of a single bullet, the urgent flight over deadly lands to escape persecution (de Leon 2015). It is not exactly easy to motivate people who live with high levels of chronic violence to fight mosquitos (Löwy 2017). At stake in this critique is the idea that suddenly funding will be made available for Malaria, for AIDS, for TB, and enormous resources are rolled out just for those problems while chronic and endemic violence is seen as unworthy of resources (if it is considered a health issue at all). Interventions that focus on singular problems have a tendency to disaggregate complex social conditions

in ways that can undermine impacts. We are not talking about misplaced priorities here, so much as how treating social context as a black-boxed constant impedes priorities that do have value.

Scholars using social medicine approaches in global health have long noted the interconnectedness of social, institutional and physical health. We know that the structural effects of inequality on health are real (Wilkinson & Pickett 2009), and that chronic stress produced by things like racism affects health outcomes (Bailey et.al.,2017; Geronimus, 2013; Briggs 2012, 2017; Becker 2008). Thinking about the economy of attention helps us trace how the social makes health a consequence of multifactorial assemblages that weigh all conditions in some sense equally, and also how focusing on one (new and high-attention-getting) target is unlikely to reach the desired effects because of the many causal social pathways involved in health. Getting people to stop smoking or eating high calorie foods will not necessarily reduce their morbidities if they still live in environments of socioeconomic and racial precarity. This insight multiplies: epigenetics points to these causal pathways as indicators of how sociality or even racism create biological communities of illness that are passed on intergenerationally (Niewöhner and Lock 2018; Lock forthcoming), a point we will return to below. Our point here is that notions of the social that are currently in play need to be revised in order to consider not only how things like social inequality are *as biological as they are 'social'* but also to recognize that the social cannot be disaggregated in ways that 'attention-getting' priorities often require.

Social medicine approaches promote the need to make visible what is consistently made invisible by the way that the economy of attention generally commands attention to only one thing (and often the most easy thing, the low hanging fruit) (Caduff 2015). Given this more wholistic approach, the focus on interconnections between health disease causation and larger social, biological, political and economic contexts that cause harms is useful here. Of course, there are initiatives within global health (and its predecessor international health) that have tried to tackle this, and long-standing critiques of donor-

driven verticalization (including critiques of MDGs, “Health system strengthening,” etc. and consider the historic WHO’s Alma Ata Conference and Primary Health Care initiative). The problem of course is that the structures tend to remain the same in all these initiatives, with little attempt to revise the methodologies along with a recurring tendency to hold things like ‘the social’ as a constant and a given rather than as the driving force behind linear and reductionistic approaches to problems that are complex and interconnected.

For instance, the World Mosquito Project, funded by Gates Foundation aims to eliminate diseases transmitted by the mosquito *Aedes aegypti* (such as dengue and Zika) by infecting the mosquito with a bacteria, *Wolbachia*, that limits the mosquito’s capacity to transmit viruses. This technological solution was thought to be something that would bypass the need for scrutinizing the social issues of poor sanitation and living conditions or the ways that these vary from place to place. However, researchers soon learned that approaches that worked well among middle class Australians worked poorly in Brazilian favelas where preoccupations with high levels of violence made implementation more difficult (Lowy 2017). Similarly, media coverage of Zika in Brazil that has constructed imagery of a warlike crisis has not only overlooked actual violence in these communities but also masked gender and social inequalities (Ribeiro et.al. 2018). Nading (2014) offered insights on how mosquito control worked and failed to work in Nicaragua where assumptions about the social entanglement of humans and mosquitos was grossly underestimated and where attention-getting campaigns misread the role of political instability making reduction of malaria risk uncertain. Here again, how the global health community turned its collective attention to the promise of a technological fix (or even a vector control fix) without considering more overarching impediments of social unrest and complex social milieus of everyday family routines suggests the need for more close scrutiny of the social and moving beyond its gloss as a complex yet static context. Efforts to trace the evidence for what has gone wrong with nearly

every anti-malaria campaign since the dawn of international health itself (see Brown 1981), points again to the oversight of assuming that the social is a constant rather than a complex interweaving of material and human conditions.

Paying attention to how the economy of attention works in global health may help avoid the reductionism that arises from ignoring complex relations of social causality while also reminding us of how often these relations exceed our taken-for-granted assumptions about the social that have dominated in the 20th century.

Anthropogenic Climate Change

Anthropogenic climate change – also referred to as the Anthropocene, or the age of *human-made environmental precarity* – is arguably one of the most pressing global health concerns we face today. Global health efforts to map the contours of this precarity is already being done in terms of: health exposures and risks from environmental disasters; increased chronic exposures to toxicants; limitations in access to food; increased pathogenicity of viral strains; augmented spread and speed of pathogen transfer; and deficient health infrastructures for dealing with these changes. At the same time, global health programs often rely on well-rehearsed languages – disasters, spread of viral, bacterial, parasitic infections – rather than reframing these problems in relation to how social medicine scholars are asking us to rethink what we mean by ‘the social’ in relation to the Anthropocene.

Consider cancer. Global health programs have targeted specific sources of cancer by focusing on individual behavioural change, in part by way of local taxation on known carcinogens. Tobacco related cancer is prominent here and is treated as the primary culprit in rising cancer morbidities, as is the tactic of increasing taxation of tobacco sales as a means of reducing smoking (Global Health 2035). On the one hand, the focus on tobacco is important and promising: it pays attention to chronic forms of morbidity (tobacco cancers) and prevention (reducing smoking). On the other hand, global health’s

insistence on defining the problem of cancer narrowly and in terms of individual social behavior reproduces the same dead ends we have seen in global health already where social behavior, as usual, is treated as a matter of individual choice, rather than as the desired end point of various machineries of industrial capitalism that have increased exposure to many chemicals that cause many forms of cancer. Scholars of the Anthropocene are pointing to the ways that toxic exposures from the air, water, food form a larger corpus of human transformation that has now not only contributed to rising cancer rates of all kinds but also put the planet at risk (of which smoking and tobacco consumption forms just one thread) (Choy 2011, Jain 2013; Weston 2017; Murphy nd.). This perspective moves questions of behavioral change out of the realm of individual choice and into the realm of global geopolitical responsibility for removing petrochemical and other toxicants at their industrial sources. In this case, moving beyond notions of the social tied to individual choice toward a social that sees climate change from chemical overexposures as a geopolitical social problem is what is called for. The recent effort on the part of journals such as the Lancet to deal with the issues of climate change (in fact they offer a whole journal on Planetary Health) is enticing in its attempt to capture the scope of the problem, and yet most of the research and recommendations cleave to familiar and well-rehearsed messages in relation to infectious diseases, disasters, etc. without taking into consideration new models of sociality (Bizley 2017; Landrigan, et.al.2018). Our sense is that we need to consider the ways that these conceptual moves are being explored as fundamental alterations, rather than reiterations, of how we conceive of the social in times of predicted planetary demise.

Scholars of the Anthropocene use environmental decline, chemical exposures, and ecosystem relationships as prompts to rethink what we mean by the social in ways that distribute responsibility away from humans and toward ecosystems as a whole. In this move, what constitutes ‘the social’ is expanded considerably. For instance, mapping the dispersal of toxic substances invites us to think about

human-animal-environmental relations in ways that disrupt our understanding of where the ‘social’ begins and where it ends but certainly always beyond humans (Tsing 2017; Haraway 2017; Vivieros de Castro 2004, Kohn 2013). Social relations here are not just human social relations, but rather relations among many ecosocial beings, including living environments, plant and bacterial systems, human technologies and animals – an approach that ultimately tasks us with rethinking our concepts but also our strategies for adaptation and survival. Symbiosis (over zero-sum combat), cohabitation (over displacement), and reconceptualizing the meanings of kin, not to mention engaging in a politics of acceptable levels of harm in order to *live with* our technology-laden chemicals are advanced as conceptual tools to help us reimagine life in ways that are both disruptive and sometimes restorative.

When the climate itself operates as an actor in the models we use to think about sustainability, what would it mean to attribute to climate, microbes, viruses and plants the capacity for sociality? Here calls for being attentive to *the social* means reimagining our notions of disease and illness, but even what counts as biology or ‘life’ in ways that can generate productive interventions (Weston 2017; Paixao, Teixeira, and Rodrigues 2017). Humans inhabit worlds that are shared living spaces -- shared by microbes, plants, animals and infrastructures that they rely on for survival -- that also constitute the social milieu, thus why would we not consider them kin-beyond-the-human? Ecosystem approaches open space for consideration of the symbiotic flow of viruses and bacteria as co-inhabitants of the planet and fellow passengers in global transit rather than as mere (or always) obstacles to human survival. At the same time, mapping morbidities onto their logical end points in ecosystems offers opportunities for thinking about things like cancer and toxic exposures as trade-offs that must be calculated alongside individual decisions about things like smoking, driving cars, flying in planes, taking probiotics to undo the effects of spraying our foods with pesticides. Classic political economic analyses of harm and harm reduction in the face of daily chemical exposures can only go so far to remedy the situation because the

lines of accountability include but also reach far beyond corporations and profiteering that make the chemicals, sell the gas, fuel the airplanes. We are all participants in this techno-chemically rich form of life. Deciphering lines of accountability for provisioning care for mutated bodies, for a life with rashes and allergies, for early deaths and childhood diagnoses of cancer is not so easy, but surely a global health that attends to these problems needs to consider how our current notions of the social, on which our political engagements have rested up to now, may have outlived their utility in helping us through these predicaments today.

Geopolitics of ‘North’ and ‘South’

The social medicine approach we are proposing puts the geopolitics of ‘North’ and ‘South’ centre stage as ripe for critique. To be sure, the “Global North/Global South” language constitutes one way to critique the long-standing colonial histories of health and development. These labels are in a sense attempted “correctives” to other concepts that were perceived as problematic (First and Third World; Developed/Un- or Under-developed). At the same time, these categories replicate many of same problems of a tacit assumption about the social that we have seen above, built into the concepts themselves.

For instance, many have called attention to the engrained assumption that knowledge about health must come primarily from the Global North, countering assumptions that theory comes from the Global North while data comes from the Global South. Critiques of this state of play abound within global health institutions (e.g. the “10/90 gap”) and among social scientists who have repeatedly accused powerful actors in the North of exporting “Western” models of illness and treatment, underrating the role of practitioners of traditional therapies, ignoring cultural variability in comprehending and responding to suffering and ignoring its social and economic causes in low and middle-income countries (see Patel, 2014 for a critique). Social medicine has long history of attempting to subvert these

hierarchies, and several traditions of social medicine were developed in the Global South to attend to this: the Latin American (including Brazilian Collective Health), South African and Indian traditions of social medicine (Kark, and Steuart 1962; Porter 2006; Susser 1993; Victora 2003; Vieira-da-Silva and Pinell 2014; Waitzkin et.al. 2001). Many academics in the Global North take this tradition seriously as source of inspiration to revitalize social medicine in their countries. Yet, such efforts remain largely piece-meal and unknown to the broader community of public health practitioners and they have tended to not engage as deep a consideration of post-colonial scholarship as we suggest would be necessary. Shula Marks' work, a historically sensitive analysis of the long-standing neocolonial vested interests that account for the failures of community health today, is a notable exception (Marks 1997).

The social medicine approach we are talking about considers the categories (and conceptual work done by) distinctions between North and South as problematic because they assume too much (and too much homogeneity) of the social. First, these categories have poor analytical power. Historically 'South' or 'tropical' became synonymous with poor or neglected, but these divisions, e.g., between privileged and neglected populations, are not necessarily geographic. For instance, nearly a hundred years ago Brazilian sanitarians explained that the "sertão" (hinterland) starts 100 meters from the central avenue of the capital Rio (Peixoto, 1922); today neglected populations (the poor, the marginal, refugees, migrants) are everywhere, while "intermediary" economies generate their own networks of power and domination, and their zones of neglect. Economic divisions exist within the Global North (the US South and rural states, Southern Italy, regions in North England, Wales and North Ireland, former Soviet states, etc.). Similarly, there are great swaths of wealth in the so-called South held by both states and private wealth individuals that get glossed over (if not ignored) in global health policy-making. Social Medicine has been traditionally attentive to the health conditions of the poor, excluded, marginal, migrants in the Global North and it remains equally suited to understanding the conditions and solutions to these

problems in the so-called global South, but the distinctions between North and South dissolve as geographic or economic characteristics.

Second, the notion that global health arrives from the North with solutions that must be cleverly ‘implemented’ in the South is hugely problematic even before considering the disparities of resources and wealth where this model operates. Consider the role that China plays in delivering health aid, building hospitals, or the role that Cuba has played in educating doctors in many countries. These examples upset normative assumptions about where knowledge and strategy come from along the North-South axis, forcing us to reconsider the utility of the terms themselves along social lines.

A social medicine interrogation of the conceptual work that underpins many global health programs relying on assumed North-South binaries offers yet another way to consider the need for rethinking ‘the social.’ If the categories of North and South no longer stand for the arrangements and circulations of knowledge, resources and health in the ways that we assume they should, perhaps it is because the categories themselves have come to be nothing more than placeholders in policy-making worlds. North and South are empty categories that get filled in with assumed relations of inequality, race, class, poverty, wealth, etc. and assumed modes of rectifying these inequities (e.g. better representation from the “South” in major organization such as the WHO), rather than as labels for things that are ambiguous and that require a good deal of ethnographic inquiry to understand, and that vary from place to place. Thus, rather than assuming that global health will always work to rectify the great divide between North and South, we might insist on figuring out what the actual conditions are in the places where global health gets done, including how knowledge, wealth and health circulate, how poverty is constituted and experienced, and who and what are already working to solve these issues, if anyone. Here, the social that circulates in Global Health could benefit a great deal from the conceptual work, particularly in relation to the taken-for-granted notion of ‘social inequality.’

The tendency in much global health work is to treat all health inequality as the same (and rooted in social inequality in the same ways) which has hampered progress, even in the integrated complex models of intervention favoured by social medicine efforts. In contrast, we might consider alternatives to the frequent tensions within global health between the constellation of local conditions (interventions adapted to local cultural specificities; the characteristics of existing local health systems; the particular needs of given population groups) and efforts to ‘scale up’ and generalize those interventions as global strategy. The focus on local needs versus things like managing global pathogens by the WHO, and the regulation of food safety by the Food and Agriculture Organization for instance, reveals complexities of causality that inform what constitutes health inequality and these complexities matter.

Human health and illness always take local form even while our models of them are enacted across both global and local spaces and epistemologies. We recall the lively literature on the concept of epigenetics and local biologies, for instance, that helps orient us to these differences. Not only are biological phenomena experienced differently in different places, in different socially, economically, racially or even religiously identified people, but one could argue that these differences are inextricably and at the same time biological, cultural, political, moral, etc. making the notion of ‘the social’ much more complex than has hitherto been assumed (Niewöhner and Lock, 2018, Lock and Nguyen 20xx). This complex rendering of the social (that blurs the biological, cultural, political, etc.) shapes not only the experience of health and illness but also the contours of inequality. Inequality is found simultaneously in one’s epigenetics and one’s environment, exploding notions of race, class and power that have dominated conversations of things like the social determinants of health inequality. We are not asking for a relativizing of the notion of inequality, but rather for a recognition that different measures of inequality could co-exist, overlap and sometimes contradict one another. Here, a return to the conceptual work being done by scholars of the Anthropocene is helpful.

Suggesting that ‘the local’ warrants more conceptual space in global health work does not mean assuming that we know what the local actually is – something that is highly problematic in a globalized world. That is, even the categories of global and local (like North and South) are problematic. While the global and the local are often conceptualized as discrete spheres, the approach we advocate moves beyond the global/local divide by drawing from the rich theorization in anthropology, as in Escobar’s notion of “glocality” (2001), Tsing’s concept of “friction” (2005) and Ong’s notion of “global assemblages” (Collier and Ong 2005), as alternative frameworks. Analyzing the complexities of social inequality as formed by global assemblages, for instance, “emphasizes their heterogeneity and perpetual movement and traces their limitations through ‘technical infrastructures, administrative apparatuses, and value regimes’” (Bemme and D’souza 2014, 853). Assemblages make tracing what is local and what is global less important than the fact that the forces coalescing and conspiring to produce inequality are complex and specific to particular histories, geographies, and social practices that are both local and global at once.

Our point is that apprehending ‘the local’ in time and space is problematic when it presumes certain things like social inequality or health inequality’ as obvious and obviously situated in dichotomous relationship to the global, a habit that recurs when reference points like Global North and Global South are invoked. Again, while much social medicine work has tended to be more structural/Marxist in orientation, treating inequality as the root source of social and physical suffering, we are advocating a need to attend to specific conditions of pathogenesis and intervention, recognizing that one size does not fit all, and thus to a breaking up of the stranglehold that the essential and uniform category of ‘social inequality’ has held on global health efforts. A renewed perspective on what Escobar has called a pluriverse design (Escobar: 2018) with its constant reflexivity regarding how ‘the global’ is at play in everything ‘local’ offers a vision of the social that moves far beyond North/South and

Global/Local contours of social inequality. Along these lines, we would also argue that remapping the social in this way also invites us to consider how social medicine is itself always already global in some sense, and thus global health might always already be doing a sort of social medicine. Our concern is what kind of ‘social’ that social medicine is doing.

Conclusion: a note on methodology

The social medicine we have mapped here draws from a long tradition of evidence that health interventions are often built upon flawed assumptions about the causes of disease and thus often lead to ineffective solutions. Historically, social medicine offered a concept of ‘the social’ that was attuned to the limitations of scientific medicine but also became routinized in ways that treated it as if it is basically the same thing in all places. Our effort has been to resist this in global health work – to resist the use of facile notions of the social, but also facile methods of apprehending the social. We have argued that exploring some of the new ways that ‘the social’ is being pursued across social science disciplines sheds light on some of the limitations seen in current global health work and points us in new directions that are worth considering. To deploy these expanded notions of the social in global health might require thinking further about what kinds of methods are best suited for this work.

Social surveys are often used in global health work to capture the ‘social determinants of health.’ Social surveys, however, frequently fail to grasp underlying pathways of pathogenesis that can only be mapped by tracing the myriad activities, relations and concepts held by community members – in short, a notion of the social that is not assumed. Among the methods useful for this work are the techniques of participant observation (from Anthropology), grounded theory (from Sociology), postcolonial studies (from History), gender complexity (from Women and Gender Studies), community participatory research (from Public Health), social constructionism and actor-network theory (from STS), various narrative approaches to data collection (from Medical Humanities) and even an approach that

contemplates how the social may need to exceed the human (in Anthropocene studies). While these approaches have similarities and differences, they all generate opportunities for moving beyond facile notions of the social. And, while it is absurd to think that any scholar might be skilled in all of these approaches, let alone use all of them, we would argue that the activities, from fact-finding to intervention planning and implementation for global health might benefit from inclusion of work from any of these fields.

Often the very fact that the methodologies from these diverse social science and humanities fields *are not all the same* is overlooked by global health research teams who assume that ‘social determinants’ can be seen and studied in much the same way by anyone with social science training (and that surveys provide a shortcut to get at these things). Other global health methodologies fall into the same trap, including use of statistical and RCT-based interventions that tend to hold “the social” as a constant, presuming that the social operates as a sort of background static in the system as opposed to a robust and teeming source of information that may be key to both efficacy and critique of the interventions being attempted. There is a robust literature on the complicated relationships between qualitative and quantitative methodologies in global health, particularly on the reductive tendencies emerging from qualitative research in global health in and around notions of the social (Smith-Morris 2016; Geissler and Kelly 2016). The assumptions and erasures of complex sociality in much global health work only bolster the ambiguous renderings of methodology as interchangeable and remind us how important it is to devote time and effort to deciphering what ‘social’ we are talking about at any time or place.

In this paper, our goal has been to open up space for rethinking concept work by challenging the meaning of ‘the social’ that is often used uncritically in global health. Building on what Holmes et.al.(2014) called for in a multidisciplinary return to social medicine in global health, we call attention

here to a more open ended and theoretically informed approach to knowledge-making and truth-formation in relation to the social. In this sense, social medicine's contribution is not just in how we collect data (although that matters too) or that we have many different ways of doing so. Rather, social medicine's contribution can be aimed at revising how we think about data and what it means in ways that are differently informed by a notion of 'the social.'

References

Adams, Vincanne 2013a. "Evidence-Based Global Public Health: Subjects, Profits, Erasures" In Joao Beihl and Adriana Petryna, eds. *When People Come First: Anthropology and Social Innovation in the Field of Global Health* Princeton University Press.

Adams, Vincanne. 2013b. *Markets of Sorrow, Labors of Faith: New Orleans in the Wake of Katrina*. Durham: Duke University Press.

Adams, Vincanne, ed. 2016 *Metrics: What Counts in Global Health* Duke University Press.

Aggleton, Peter and Richard Parker. 2015 "Moving Beyond Biomedicalization in the HIV Response: Implications for Community Involvement and Community leadership among Men Who Have Sex With Men and Transgender People" *Am.J. Public Health* 105(8): 1552-1558.

doi: [10.2105/AJPH.2015.302614](https://doi.org/10.2105/AJPH.2015.302614)

Anderson, Warwick. 2014. "Making Global Health History: The Postcolonial Worldliness of Biomedicine." *Social History of Medicine*, 27(2): 372-384.

Bailey, Zinzi D., Nancy Krieger, Madina Agénor, Jasmine Graves, Natalia Linos, Mary T Bassett. 2017. "Structural racism and health inequities in the USA: evidence and interventions." *The Lancet*, 389: 1453-1463

Bell, Kirsten (2018) "Whatever happened to the 'social' science in Social Science & Medicine? On golden anniversaries and gold standards" *Social Science and Medicine*
<https://doi.org/10.1016/j.socscimed.2018.04.009>

Becker, Gay. 2004. "Deadly Inequality in the Health Care "Safety Net":Uninsured Ethnic Minorities' Struggle to Live With Life-Threatening Illness" *Medical Anthropology Quarterly* 18(2):258-275.
<https://doi.org/10.1525/maq.2004.18.2.258>

Béhague, Dominique, Charlotte Tawiah, Mikey Rosato, Telesphore Some, and Joanna Morrison. "Evidence-based policy-making: the implications of globally-applicable research for context-specific problem-solving in developing countries." *Social Science & Medicine* 69, no. 10 (2009): 1539-1546.

Bemme, Doerte, and Nicole A. D'souza. 2014. "Global Mental Health and Its Discontents: An Inquiry into the Making of Global and Local Scale." *Transcultural Psychiatry*, 51 (6): 850–874.

Birn, Anne Emanuelle. 2009. The stages of international (global) health: histories of success or success of history, *Global Public Health*, 4(1): 50-68.

Biruk, Crystal. 2018. *Cooking Data: Culture and Politics in an African Research World*. Durham: Duke University Press.

Bizley, Richard. 2017. “A Sixth Extinction? Why Planetary Health Matters” *The Lancet Planetary Health*, Editorial. Volume 1, Issue 5.163. DOI: [https://doi.org/10.1016/S2542-5196\(17\)30083-9](https://doi.org/10.1016/S2542-5196(17)30083-9)

Brandt, Allan. 2013. How AIDS invented global health. *New England Journal of Medicine*, 368(23): 2149-2152.

Briggs, Laura 2012. *Somebody’s Children: The Politics of Transnational and Transracial Adoption*. Durham: Duke University Press.

Briggs, Laura 2017. *How All Politics Became Reproductive Politics: From Welfare Reform to Foreclosure to Trump*. Oakland, California: University of California Press.

Brown Theodore, Marcos Cueto and Elisabeth Fee. 2006. The World Health Organization and the transition from “international” to “global” public health. *American Journal of Public Health*, 96(1): 62-72.

Brown, Richard 1981. *Rockefeller Medicine Men: Medicine and Capitalism in America*. Berkeley: University of California Press.

Buse, Kent, and Gill Walt. "and global public-private health partnerships: In search of 'good' global health governance." *The Global Social Policy Reader* (2009): 195.

Caduff, Carlo. 2015. *The Pandemic Perhaps. Dramatic Events in a Public Culture of Danger*. Berkeley: University of California Press.

Choy, Tim. 2011. *Ecologies of Comparison: An Ethnography of Endangerment in Hong Kong*. Durham: Duke University Press.

Cueto, Marcus. 2004. The origins of primary health care and selective primary health care, *American Journal of Public Health*, 94(11): 186'-1874.

Collier, Stephen J., and Aihwa Ong. 2005. "Global Assemblages, Anthropological Problems." In *Global assemblages: Technology, Politics, and Ethics as Anthropological Problems*, edited by Stephen Collier and Aihwa Ong, 3–21. Malden, MA: Wiley-Blackwell.

Crane, Johanna. 2013. *Scrambling for Africa: AIDS, Expertise and the Rise of American Global health Science*. Ithaca: Cornell University Press.

Cueto, Marcos. 2013. "Malaria and Global Health at the Turn of the 21st Twenty-first Century: A Return to the "Magic Bullet" Approach?" In: Biehl, João; Petryna, Adriana (ed.). *When People Come First: Evidence, Actuality, and Theory in Global Health*. Princeton; Princeton University Press, pp. 10-30.

Das, Veena, 2003. “Technologies of Self: Poverty and Health in an Urban Setting”, in R. Vasudevan et al. (eds), *Sarai Reader 2003: Shaping Technologies*. New Delhi: Sarai, 95-102.

De Leon, Jason. 2015. *The Land of Open Graves: Living and Dying on the Migrant Trail*. Berkeley: University of California Press.

Dilger, Hansjörg and Dominik Mattes (2018) Im/mobilities and dis/connectivities in medical globalisation: How global is Global Health?, *Global Public Health*, 13:3, 265-275, DOI: [10.1080/17441692.2017.1414285](https://doi.org/10.1080/17441692.2017.1414285)

Dumit, Joe. 2012. *Drugs for Life: How Pharmaceutical Companies Define Our Health*. Durham: Duke University Press.

Erikson Susan. (2016). Metrics and market logics of global health. In Adams V., editor. (Ed.), *Metrics: What counts in global health* (pp. 147–162). Durham, NC: Duke University Press.

Escobar, Arturo. 2001. “Culture Sits in Places: Reflections on Globalism and Subaltern Strategies of Localization.” *Political Geography*, 20 (2): 139–174.

Escobar, Arturo. 2018. *Designs for the pluriverse: radical interdependence, autonomy, and the making of worlds*. Duke University Press.

Fassin, Didier. 2012. The obscure object of global health. In Marcia Inhorn and Emilie Wentzell (eds), *Medical Anthropology at the Intersections: History, Activisms and Futures*. Duke University Press pp.95-115.

Ferguson, James 2010. The Uses of Neoliberalism *Antipode* 41: 166-184.

<https://doi.org/10.1111/j.1467-8330.2009.00721.x>

Foucault, Michel. 2000. “the Birth of Social Medicine”, In *Power: The Essential Works of Michel Foucault 1954-1984. Volume Two (134-156)*. London: Allen Lane.

Foucault, Michel. 2004. “The Crisis of Medicine or the Crisis of Antimedecine?”.

Foucault Studies, 1: 5-19.

Foucault, Michel. 2012. “The Incorporation of the Hospital into Modern Technology”. In *Space, Knowledge and Power: Foucault and Geography* (pp. 141-151). Translated by Edgar Knowlton Jr., William J. King, and Stuart Elden. Ashgate Publishing Limited

Geissler, Paul Wenzel. 2015. “Introduction: A Life Science in Its African Para-State”. In Paul Wenzel Geissler. Ed. *Para-States and Medical Science: Making African Global Health*. Durham: Duke University Press; 1-44.

Geissler, Paul Wenzel and Anne Kelly. 2016. “Field Station as Stage: Re-enacting scientific work and life in Amani, Tanzania.” *Social Studies of Science* 46(6). <https://doi.org/10.1177/0306312716650045>

Geissler, Paul Wenzel and Catherine Molyneux, eds., 2017. *Evidence, Ethos and Experiment: The Anthropology and History of Medical Research in Africa*. Durham: Duke University Press.

Geronumis, Arline. 2013. “Deep Integration: Letting the Epigenome Out of the Bottle Without Losing Sight of the Structural Origins of Population Health” *American Journal of Public Health*, Supplement 1, 2013, Vol 103, No. S1, S56-S63

Gaudilliere, Jean-Paul 2014. “De la santé publique internationale à la santé globale. L’OMS, la Banque mondiale et le gouvernement des thérapies chimiques” in Dominique Pestre. Ed. *Le gouvernement des technosciences Gouverner le progrès et ses dégâts depuis 1945* Le Decouverte, pp. 65-96.

Gofin, Jame. 2006. “On ‘A Practice of Social Medicine’ by Sidney and Emily Kark. *Social Medicine* 1(2):107-115.

Greene, Jeremy. 2011. Making medicines essential: The emergent centrality of pharmaceuticals in global health. *BioSocieties*, 6(1): 10-33.

Hacking, Ian. 2000. *The Social Construction of What?* Cambridge: Harvard University Press.

Haraway, Donna J. 2016. *Staying with the Trouble: Making Kin in the Chthulucene*. Durham: Duke University Press.

Hayden, Cori. 2003. *When Nature Goes Public: The making and Unmaking of Bioprospecting in Mexico*. Princeton: Princeton University Press.

- Hodges, Sarah. 2012. "The Global Menace". *Social History of Medicine*, 25 (3): 719–728.
- Holmes, Seth M., Greene, Jeremy A. & Stonington, Scott D. 2014 "Locating global health in social medicine," *Global Public Health*, 9:5, 475-480, DOI: [10.1080/17441692.2014.897361](https://doi.org/10.1080/17441692.2014.897361)
- Horton, Richard. 2018a. "Offline: NCDs, WHO, and the neoliberal utopia". *Lancet*, 391: 2402. June 16.
- Horton, Richard. 2018b. "Offline: Defending the left hand of the state." *Lancet*, 391, 2484. June 23.
- Jamison, D.T., Summers, L.H., Alleyne, G., Arrow, K.J., Berkley, S., Binagwaho, A., Bustreo, F., Evans, D., Feachem, R.G., Frenk, J. and Ghosh, G., 2013. Global health 2035: a world converging within a generation. *The Lancet*, 382(9908), pp.1898-1955.
- Jain, Lochlann. 2013. *How Cancer Becomes Us*. Berkeley: University of California Press.
- Jones, David S., Jeremy Greene, Jacalyn Duffin and John Harley Warner. 2014. "Making the Case for History in Medical Education" *Journal of the History of Medicine and Allied Sciences*
doi:10.1093/jhmas/jru026
- Kark, S. L, and Steuart, G. eds. 1962. *A Practice of Social Medicine*. Edinburgh: E & S Livingstone.
- Kelly, Ann and Linsey McGoe. 2018. Facts, Power and Global Evidence: A new empire of truth"
Economy and Society special issue of *Economy and Society* 47:1, 1-26, DOI:
10.1080/03085147.2018.1457261
- King, Nicolas 2002. Security, Disease, Commerce: Ideologies of Postcolonial Global Health. *Social Studies of Science*, 32(5-6): 763–789.

Kohn, Eduardo 2013. *How Forests Think*. Berkeley: University of California Press.

Landrigan, Philip, Richard Fuller, Andy Haines, Nick Watts Gina McCarthy. 2018. "Pollution Prevention and Climate Change Mitigation: Measuring the Health Benefits of Comprehensive Interventions" *The Lancet, Planetary Health, Comment*. Vol 2. Dec. 515-516.

Lock, Margaret (forthcoming) "Toxic Environments and the Embedded Psyche" *Medical Anthropology Quarterly*, special issue on The Global Psyche.

Lock, Margaret and Vinh-Kim Nguyen. 2010. *An Anthropology of Biomedicine*. Wiley-Blackwell Publishers.

Löwy, Ilana. 2017. Leaking containers: success and failure in controlling the mosquito *Aedes aegypti* in Brazil, *American Journal of Public Health*, 107(4): 517-524.

Marks, Shula. (1997). "South Africa's Early Experiment in Social Medicine: Its Pioneers and Politics." *American Journal of Public Health* 87(3):452-9.

McGoey, Lindsay. 2015. *No Such Thing as a Free Gift: The Gates Foundation and the Price of Philanthropy*. London: Verso.

Metzl, Jonathan and Helena Hansen. 2014. "Structural Competency: Theorizing a new Medical Engagement with Stigma and Inequality" *Soc.Sci.Med* 103: 126-133.

<https://doi.org/10.1016/j.socscimed.2013.06.032>

Murphy, Michelle. 2017. *The Economization of Life*. Durham and London: Duke University Press.

Murphy, Michelle. N.D. Reimagining Chemicals with and Against technoscience. Paper presented to the Department of Anthropology, History and Social Medicine, UCSF, 2017.

Nading, Alex. 2014. *Mosquito Trails: Ecology, Health and the Politics of Entanglement*. Berkeley: University of California Press.

Nguyen, Vinh-Kim. 2010. *The Republic of Therapy: Triage and Sovereignty in West Africa's Time of AIDS*. Durham: Duke University Press.

Niewöhner, Jörg and Margaret Lock. 2018. Situating local biologies: Anthropological perspectives on environment/human entanglements . *BioSocieties* <https://doi.org/10.1057/s41292-017-0089-5>

Ollila, Eeva. "Global health priorities—priorities of the wealthy?." *Globalization and health* 1.1 (2005): 6.

Ong, Aihwa. 2006. *Neoliberalism as Exception. Mutations in Citizenship and Sovereignty*. Durham and London: Duke University Press.

Ortega, Francisco. 2014. *Corporeality, Medical Technologies and Contemporary Culture*. New York: Routledge.

Packard, Randall 2016. *A History of Global Health: Interventions Into the Lives of Other People*. Baltimore: Johns Hopkins University Press.

Paixão, Enny, Maria Gloria Teixeira, and Laura C Rodrigues. 2017. Zika, chikungunya and dengue: the causes and threats of new and reemerging arboviral diseases. *BMJ Global Health*, 3:e000530.
doi:10.1136/ bmjgh-2017-000530

Patel, Vikram. 2014. “Why mental health matters to global health.” *Transcultural Psychiatry*, 51:777-89.

Peixoto, Afranio. 1998. *Defensa Sanitaria do Brasil*, Rio de Janeiro, Typografia Revista dos Tribunais, 1922, quoted in Gilberto Hochman, *O Era de Sanamento*, Rio de Janeiro, Editora Hucitec. 70.

Peterson, Kristin. 2014. *Speculative Markets: Drug Circuits and Derivative Life in Nigeria*. Durham: Duke University Press.

Petryna, Adriana. 2009. *When Experiments Travel: Clinical Trials and the Global Search for Human Subjects*. Princeton: Princeton University Press.

Porter Dorothy. 2006 How Did Social Medicine Evolve, and Where Is It Heading? PLoS Med 3(10): e399. <https://doi.org/10.1371/journal.pmed.0030399>

Ribeiro, Barbara, Sarah Hartley, Brigitte Nerlich, Rusi Jaspal. (2018). “Media coverage of the Zika crisis in Brazil: The construction of a ‘war’ frame that masked social and gender inequalities,” *Social Science & Medicine*, 200: 137-144.

Rose, Nikolas. 2007. *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century*. Princeton: Princeton University Press.

Rose, Nikolas and Novas, Carlos. 2005. “Biological citizenship”. In: Ong, Aihwa and Collier, Stephen J, (eds.) *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems*. Blackwell Publishing, Oxford, pp. 439-463.

Schrecker, Ted. The State and Global Health. In (Ed.), *The Oxford Handbook of Global Health Politics*. : Oxford University Press,. Retrieved 25 Dec. 2018, from <http://www.oxfordhandbooks.com/view/10.1093/oxfordhb/9780190456818.001.0001/oxfordhb-9780190456818-e-18>.

Schuller, Mark. 2016. *Humanitarian Aftershocks in Haiti*. New Brunswick: Rutgers University Press.

Smith-Morris, Carolyn. 2016. "When Numbers and Stories Collide: RCTs and The Search for Ethnographic Fidelity in the Veterans Administration". In Vincanne Adams (Ed.) *Metrics: What Counts in Global Health* Duke University Press, Global Health Series.

Sobo, EJ. 2016. "What is Herd Immunity, and How Does it Relate to Pediatric Uptake? US Parent Perspectives." *Soc.Sci.Med.* Sep;165:187-195. doi: 10.1016/j.socscimed.2016.06.015.

Stonington S, Holmes SM, eds. *Social Medicine in the Twenty-First Century. Public Library of Science Medicine.* 2006; 3(20):e455.

Stonington, Scott D., Seth M. Holmes, Helena Hansen, Jeremy A. Greene, Keith A. Wailoo, Debra Malina, Ph.D., Stephen Morrissey, Paul E. Farmer, and Michael G. Marmot, *Case Studies in Social Medicine — Attending to Structural Forces in Clinical Practice.* NEJM, 379: 20 nejm.org November 15, 2018

Storeng, Katerini T., and Dominique P. Béhague. 2014. "'Playing the Numbers Game': Evidence-based Advocacy and the Technocratic Narrowing of the Safe Motherhood Initiative." *Medical Anthropology Quarterly* 28.2: 260-279.

Susser, Marvyn. 1993. "A South African Odyssey in Community Health: A Memoir of the Impact of the Teachings of Sidney Kark." *American Journal of Public Health*, 83 (7): 1039-1042.

Tichenor, Marlee. 2016, “The Power of Data: Global Health Citizenship and the Senegalese Data Retention Strike.” in V Adams (ed.), *Metrics: What Counts in Global Health*. Critical Global Health, Durham, NC: Duke University Press, pp. 105-124.

Ticktin, Miriam. 2011. *Casualties of Care: Immigration and the Politics of Humanitarianism in France*. Berkeley: University of California Press.

Tsing, Anna Lowenhaupt. 2005. *Friction: An Ethnography of Global Connection*. Princeton, NJ: Princeton University Press.

Tsing, Anna, Heather Swanson, Elaine Gan and Nils Bubandt, eds., 2017. *Arts of Living on a Damaged Planet Minneapolis*: University of Minnesota Press.

Van der Geest, Sjaak and Susan Reynolds Whyte, eds. 1988. *The Context of Medicines in Developing Countries: Studies in Pharmaceutical Anthropology*. Dordrecht: Kluwer.

Vaughan, Megan. 1991. *Curing Their Ills: Colonial Power and African Illness*. Stanford: Stanford University Press.

Victoria CG (2003) “Latin American social medicine.” *American Journal of Public Health*, 93: 1987.

Vidal, Fernando and Ortega, Francisco. 2017. *Being Brains: Making the Cerebral Subject*. New York: Fordham University Press.

Vieira-da-Silva, Ligia Maria, and Pinell, Patrice. 2014. "The genesis of collective health in Brazil."

Sociology of Health & Illness, 36(3): 432–446.

Virchow, Rudolph (1849) "Communications about the Typhus Epidemic in Upper Silesia," *Arch. Path.*

Anat. Physiol. 1849:2: 143-322.

Viveiros de Castro, Eduardo. 2004. "Exchanging Perspectives: The Transformation of Objects into

Subjects in Amerindian Ontologies." *Common Knowledge*, 1(3)

Waitzkin, Howard. 1991. *The Politics of Medical Encounters: How Patients and Doctors Deal with*

Social Problems. New Haven: Yale University Press.

Waitzkin, H., Iriart, C., Estrada, A., & Lamadrid, S. (2001). *Social Medicine Then and Now: Lessons*

From Latin America. American Journal of Public Health, 91(10), 1592–1601.

Weindling, Paul. 1995. *International Health Organizations and Movements, 1918-1939*. Oxford: Oxford

University Press.

Weston, Kath. 2017. *Animate Planet. Making Visceral Sense of Living in a High-Tech Ecologically*

Damaged World. Durham: Duke University Press.

Whyte, Susan Reynolds, Sjaak Van Der Geest and Anita Hardon. 2003. *The Anthropology of*

Pharmaceuticals. Cambridge: Cambridge University Press.

Wilkinson, Richard G. and Pickett, Kate. 2009. *The Spirit Level: Why More Equal Societies Almost Always Do Better*. New York and London: Allen Lane

¹. This article is born from an international workshop at Kings College London (funded by the

Wellcome Trust and organized by Jeremy Greene, Nikolas Rose, David Jones, and Carlo Caduff) held in May 2018.

² . This period could be broken into multiple subset eras, such as the interwar period in which the Society of Nations and the Rockefeller Foundation focused on vertical eradication public health campaigns (Weindling 1995; Packard 2016), and the post-war period that gave rise to various iterations of social medicine under the rubric of international health development (including the rise and funding of fields such as Medical Sociology and Medical Anthropology, International Health Development Studies as well as elements of the WHO's Alma Ata and the Primary Care movement).

³ Some other exemplary clinically-situated programs are at Harvard University, the University of North Carolina Chapel Hill, University of Ontario, American University in Lebanon, The State University of Rio de Janeiro and many more.

⁴ One reason for this trend is likely a fear of the politics in the label: claims to be doing Social Medicine are seen as allied with political socialism. This discursive hangover from the Cold War still has more potent effects in some countries than others (the USA being a good example of a country with a serious hangover). There may, however, be other reasons. The active marginalisation of knowledge about the social (as opposed to the biological, the genetic, or the statistical) in many fields of science is another possible reason. Scholarship on the social is often set against (as if it is not even) science, therefore lacking some sort of credibility in both health sciences and health policy (we will say more about the issue of 'the social' below). Finally, we also sense that Social Medicine goes unrecognized in part because it is a victim of broader academic trends that have made "old" fields of inquiry and intervention seem out of date and unhelpful. This particular tendency, resolutely neoliberal, has forced academic departments to splinter and silo themselves under the tyranny of demands for innovation -- to make their field seem new and different by giving it a new or more refined name, or merging it with other fields -- rather than simply sticking with the old rubrics (even if what has been done before in these fields still works). Thus Social Medicine may be a victim of political economic movements that have little to do with changes in the commitments of scholars, intellectually or practically.

⁵ The turn to Global Health was a complex consequence of the WHO crisis of the 80, the rise of neo-liberal policies, the growing influence private donors and public-private partnerships, and a new focus on emerging diseases – above all AIDS—and technological solutions to health crises (Birn, 2009; Brandt, 2013; Brown, Cueto & Fee, 2006; Fassin, 2012; King, 2002). This turn erased the earlier tensions between proponents of primary health care—strongly advocated in the 1970s by WHO's directors Halfdan Mahler -- to its much more restrictive variant, the selective primary health. While advocates of primary health care stressed the importance of non medical determinants of health, advocates of selective primary health care, and later of access to essential drugs and universal health care, especially in its "minimalist" version, eschewed issues such as inequality, violence or discrimination and accentuated access to health care structures and drugs (Cueto, 2004, Greene, 2011).

⁶ . WHO Commission on the Social Determinants of Health. Final Report. 20018

http://apps.who.int/iris/bitstream/handle/10665/43943/9789241563703_eng.pdf;jsessionid=810A3B28E546EAE9E42C2F29CAAB47B8?sequence=1

⁷ We are inspired in part by Ian Hackings' (2000) undertaking in *The Social Construction of What?*.

⁸ Global Health 2035:

<http://dcp3.org/sites/default/files/resources/Global%20Health%202035%20Report.pdf>

⁹ This is not to say that the nation-state has lost all visibility. In fact one could argue that with the rise of right wing nationalisms, there is a greater presence of a menacing nation state than we have seen in nearly a century. However, we point here to the widespread decline of national commitments to health care in many regions of the world

¹⁰ Indeed, some states have often abused power in the name of health. State-supported sterilization campaigns, promoted as a “solution” for the seemingly self-evident “problem” of “over-population” are only one example. The very concern with “over-population” demonstrates how problematic it is to take understandings of the social for granted. What constitutes the social in the eyes of the state is itself an object of contestation.